FACT SHEET

# Critical Access Hospital

*LEGISLATION ENACTED AS PART OF THE BALANCED BUDGET ACT (BBA) OF 1997 authorized states to establish State Medicare Rural Hospital Flexibility Programs (Flex Program), under which certain facilities participating in Medicare can become Critical Access Hospitals (CAH). The following providers may be eligible to become CAHs:*

- *Currently participating Medicare hospitals;*
- *Hospitals that ceased operation during the 10 year period from November 29, 1988 through November 29, 1999; or*
- *Health clinics or centers (as defined by the State) that previously operated as a hospital before being down-sized to a health clinic or center.*

*Unlike facilities such as Medicare Dependent Hospitals or Sole Community Hospitals, CAHs represent a separate provider type with their own Medicare Conditions of Participation as well as a separate payment method.*

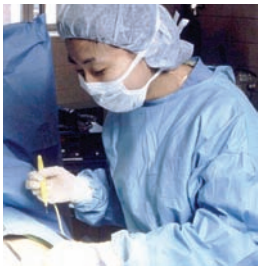
## Critical Access Hospital Designation

A hospital must meet the following criteria to be designated a CAH:

- Be located in a state that has established a State Flex Program (as of August 2005, only Connecticut, Delaware, Maryland, New Jersey, and Rhode Island did not have such a program);
- Be located in a rural area or be treated as rural under a special provision that allows qualified hospital providers in urban areas to be treated as rural for purposes of becoming a CAH;
- Furnish 24-hour emergency care services, using either on-site or on-call staff;
- Provide no more than 25 inpatient beds;
- Have an average annual length of stay of 96 hours or less; and
- Be located either more than 35 miles from the nearest hospital or CAH or more than 15 miles in areas with mountainous terrain or only secondary roads OR be State certified by December 31, 2005 as a "necessary provider" of health care services to residents in the area.

## Critical Access Hospital Payments

Medicare pays CAHs for most inpatient and outpatient services to Medicare beneficiaries on the basis of 101 percent of their allowable and reasonable costs. Under the Medicare ambulance benefit, if CAHs own and operate the only ambulance service within 35 miles, they are also paid based on a reasonable cost basis for ambulance services. CAHs are not subject to the Inpatient Prospective Payment Systems (IPPS) and Hospital Outpatient Prospective Payment System (OPPS).



The Medicare Part A and Part B deductible and coinsurance rules applicable to hospital services also apply to CAHs. All outpatient CAH services other than pneumococcal pneumonia vaccines, influenza vaccines, related administration of the vaccines, screening mammograms, and clinical diagnostic laboratory tests are subject to Medicare Part B deductible and coinsurance.

## Reasonable Cost Payment Principles that Do NOT Apply to Critical Access Hospitals

Payment for inpatient or outpatient CAH services is NOT subject to the following reasonable cost principles:

- Lesser of cost charges; and
- Reasonable compensation equivalent limits.

In addition, payment to a CAH for inpatient CAH services is not subject to ceilings on hospital inpatient operating costs or the 1-day or 3-day preadmission payment window provisions applicable to hospitals paid under the IPPS and OPPS.

## Election of Standard Payment Method or Optional (Elective) Payment Method

### *Standard Payment Method—Cost-Based Facility Services, With Billing of Carrier for Professional Services*

Under Section 1834(g) of the Social Security Act (the Act), CAHs are paid under the Standard Payment Method unless they timely elect in writing to be paid under the Optional (Elective) Payment Method. For cost reporting periods beginning on or after January 1, 2004, outpatient CAH services payments have been increased to the lesser of:

- 80 percent of the 101 percent of reasonable costs for outpatient CAH services; or
- 101 percent of the reasonable cost of the CAH in furnishing outpatient CAH services less the applicable Medicare Part B deductible and coinsurance amounts.

Payment for professional medical services furnished in a CAH to registered CAH outpatients is made by the Medicare Carrier under the Medicare Physician Fee Schedule (MPFS), as is the case when such professional services are furnished in a hospital outpatient department. For purposes of CAH payment, professional medical services are defined as services furnished by a physician or other qualified practitioner.

### *Optional (Elective) Payment Method—Cost-Based Facility Services Plus 115 Percent Fee Schedule Payment for Professional Services (Method 2)*

Under Section 1834(g) of the Act, a CAH may elect the Optional (Elective) Payment Method, under which it bills the Medicare Fiscal Intermediary (FI) for both facility services and professional services to its outpatients. However, even if a CAH makes this election, each practitioner furnishing professional services to CAH outpatients can choose whether to:

- Reassign his or her billing rights to the CAH, agree to being included under the Optional (Elective) Payment Method, attest in writing that he or she will not bill the Carrier for professional services furnished in the CAH outpatient department, and look to the CAH for payment for the professional services; or
- File claims for his or her professional services with the Carrier for standard payment under the MPFS (i.e., either by billing directly to the Carrier or by authorizing the CAH to bill on his or her behalf via a valid reassignment of benefits).

If a physician or other practitioner reassigns his or her Part B billing rights and agrees to be included under a CAH's Optional (Elective) Payment Method, he or she must not bill the Carrier for any outpatient professional services furnished at the CAH once the reassignment becomes effective. For each physician or practitioner who agrees to be included under the Optional (Elective) Payment method and reassigns benefits accordingly, the CAH must forward a copy of the completed assignment form (Form CMS 855R) to the FI and Carrier and keep the original on file. Each practitioner must sign an attestation which clearly states that he or she will not bill the Carrier for any services furnished in the CAH outpatient department once the reassignment has been given to the CAH. This attestation will remain at the CAH. The Optional (Elective) Payment Method remains in effect for the entire cost reporting period and applies to all CAH professional services furnished in the CAH outpatient department by physicians and practitioners who have agreed to be included under the Optional (Elective) Payment Method, completed a Form CMS 855R, and attested in writing that they will not bill the Carrier for their outpatient professional services. An Optional (Elective) Payment Method election and each practitioner's agreement to be included under the election must be renewed yearly based on the cost reporting year. Form CMS 855R can be found at **www.cms.hhs.gov/CMSForms/CMSForms/list.asp** on the CMS website.

As of January 1, 2004, payment for outpatient CAH services under the Optional (Elective) Method is based on the sum of:

- For facility services, the lesser of 80 percent of 101 percent of the reasonable cost of the CAH in furnishing CAH services OR 101 percent of the outpatient CAH services less applicable Medicare Part B deductible and coinsurance amounts; and
- For physician professional services, 115 percent of the allowable amount, after applicable deductions, under the MPFS. Payment for nonphysician practitioner professional services is 115 percent of the amount that would otherwise be paid for the practitioner's professional services under the MPFS.

To elect the Optional (Elective) Payment Method or to change a previous election, a CAH should notify the FI at least 30 days in before the start of the affected cost reporting period.

Effective January 1, 2007, the payment amount is 80 percent of the MPFS for telehealth services when the distant site physician or other practitioner is

located in a CAH that has elected the Optional (Elective) Payment Method and the physician or practitioner has reassigned his or her benefits to the CAH.

## Medicare Rural Pass-Through Funding for Certain Anesthesia Services

CAHs may participate in the Medicare Rural Pass-Through Program to secure reasonable cost-based funding for certain anesthesia services as an incentive to continue to serve the Medicare population in rural areas. The ***Code of Federal Regulations (CFR)*** under 42 CFR 412.113 lists the specific requirements hospitals or CAHs must fulfill to receive rural pass-through funding from Medicare for anesthesia services furnished by Certified Registered Nurse Anesthetists (CRNA) that they employ or contract with to furnish such services to CAH patients. CAHs that qualify for a CRNA pass-through exemption receive reasonable cost for CRNA professional services, regardless of whether they choose the Standard Payment Method or the Optional (Elective) Payment Method for outpatient services.

## Health Professional Shortage Area Incentive Payments

If the CAH is located within a primary medical care Health Professional Shortage Area (HPSA), physicians who furnish outpatient professional services in the CAH are eligible for a 10 percent HPSA incentive payment. If a CAH located in such a HPSA elects the Optional (Elective) Payment Method, payments to the CAH for professional services of physicians in the outpatient department will be 115 percent of the otherwise applicable MPFS amount multiplied by 110 percent.

## Physician Scarcity Area Bonus Payments

Primary and specialty physicians affiliated with a CAH may also be eligible for a Physician Scarcity Area (PSA) bonus payment of five percent if the CAH is located in an area with few physicians available. One of the following modifiers must accompany the Healthcare Common Procedure Coding System code to indicate the type of physician:

- AG—Primary physician; or
- AF—Specialty physician.

If a CAH located in a PSA elects the Optional (Elective) Payment Method, payments to the CAH for professional services of physicians in the outpatient department will be 115 percent of the otherwise applicable MPFS amount multiplied by 105 percent.

## Additional Medicare Prescription Drug, Improvement, and Modernization Act of 2003 Provisions that Impact Critical Access Hospitals

For services furnished on or after January 1, 2005, Section 405 (b) extends reasonable cost reimbursement for CAH costs of compensating physician assistants, nurse practitioners, and clinical nurse specialists who are on call to furnish emergency services. Under previous law, this coverage was limited to compensation for physicians who were on call to furnish emergency services.

Section 405(c) states that periodic interim payments will be paid every two weeks for CAH inpatient services furnished on or after July 1, 2004 for CAHs that apply and qualify for the periodic interim payment method.

Section 405(d) mandates that for cost reporting periods beginning on and after July 1, 2004, each physician or other practitioner furnishing professional services in the CAH is not required to reassign his or her Medicare Part B benefits to the CAH in order for the CAH to elect the Optional (Elective) Payment Method. For CAHs that elected the Optional (Elective) Payment Method before November 1, 2003 for a cost reporting period that began on or after July 1, 2001, the effective date of the rule is retroactive to July 1, 2001. For CAHs that elected the Optional (Elective) Payment Method on or after November 1, 2003, the effective date of the rule is July 1, 2004.

Under Section 405(e), beginning on January 1, 2004, CAHs may operate up to 25 beds for acute (hospital-level) inpatient care, subject to the 96-hour average length of stay for acute care patients. For CAHs with swing bed agreements, any of its beds may be used to furnish either inpatient acute care or Skilled Nursing Facility level swing bed services. Prior to January 1, 2004, CAHs could not operate more than 15 acute care beds or if they had a swing bed agreement, 25 beds.

Section 405(g) states that for cost reporting periods beginning on or after October 1, 2004, CAHs may establish psychiatric units and/or rehabilitation units that are CAH distinct parts (DP). The total number of beds in each CAH DP may not exceed ten. These beds will not count against the CAH inpatient bed limit of 25. Psychiatric and rehabilitation DPs must meet the applicable requirements for such beds in short-term general acute care hospitals, and Medicare payments will equal payments that would be made to general short-term acute care hospitals for these services (i.e., payments that are made under the Inpatient Psychiatric Prospective Payment System or the Inpatient Rehabilitation Facility Prospective Payment System). Therefore, payment for services in DP units of CAHs is not made on a reasonable costs basis.

Section 405(h) mandates that effective January 1, 2006, the provision permitting a state to waive the distance requirements for CAH status via State "necessary provider" designation has sunset. Providers that gained CAH status via "necessary provider" designations prior to January 1, 2006 are grandfathered as CAHs on and after January 1, 2006.

## Grants to States Under the Medicare Rural Hospital Flexibility Program

The Flex Program, which was authorized by Section 4201 of the BBA, Public Law 105-33, consists of two separate but complementary components:

- A Medicare reimbursement program that provides reasonable cost reimbursement for Medicare-certified CAHs is administered by the Centers for Medicare & Medicaid Services (CMS); and
- A State grant program that supports the development of community-based rural organized systems of care in the participating states is administered by the Health Resources and Services Administration through the Federal Office of Rural Health Policy.

To receive funds under the grant program, states must apply for the funds and engage in rural health planning through the development and maintenance of a State Rural Health Plan that:

- Designates and supports the conversions of CAHs;
- Promotes emergency medical services (EMS) integration initiatives by linking local EMS with CAHs and their network partners;
- Develops rural health networks to assist and support CAHs;
- Develops and supports quality improvement initiatives; and
- Evaluates State programs within the framework of national program goals.

## HELPFUL RURAL HEALTH WEBSITES

### CENTERS FOR MEDICARE & MEDICAID SERVICES' WEBSITES

**CMS Forms**
www.cms.hhs.gov/CMSForms/CMSForms/list.asp

**CMS Mailing Lists**
www.cms.hhs.gov/apps/mailinglists

**Critical Access Hospital Provider Center**
www.cms.hhs.gov/center/cah.asp

**Federally Qualified Health Centers Provider Center**
www.cms.hhs.gov/center/fqhc.asp

**Hospital Provider Center**
www.cms.hhs.gov/center/hospital.asp

**HPSA/PSA (Physician Bonuses)**
www.cms.hhs.gov/HPSAPSAPhysicianBonuses

**Internet-Only Manuals**
www.cms.hhs.gov/Manuals/IOM/list.asp

**Paper-Based Manuals**
www.cms.hhs.gov/Manuals/PBM/list.asp

**Medicare Learning Network**
www.cms.hhs.gov/MLNGenInfo

**Medicare Modernization Update**
www.cms.hhs.gov/MMAUpdate/MMU/list.asp

**MLN Matters Articles**
www.cms.hhs.gov/MLNMattersArticles

**Physician's Resource Partner Center**
www.cms.hhs.gov/center/physician.asp

**Regulations & Guidance**
www.cms.hhs.gov/home/regsguidance.asp

**Rural Health Center**
www.cms.hhs.gov/center/rural.asp

**Telehealth**
www.cms.hhs.gov/Telehealth

### OTHER ORGANIZATIONS' WEBSITES

**American Hospital Association Section for Small or Rural Hospitals**
www.aha.org/aha/key_issues/rural/index.html

**Government Printing Office—Code of Federal Regulations**
www.gpoaccess.gov/cfr/index.html

**Health Resources and Services Administration**
www.hrsa.gov

**National Association of Community Health Centers**
www.nachc.org

**National Association of Rural Health Clinics**
www.narhc.org

**National Rural Health Association**
www.nrharural.org

**Rural Assistance Center**
www.raconline.org

**U.S. Census Bureau**
www.census.gov



**Medicare Contracting Reform (MCR) Update**

Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) Congress mandated that the Secretary of the Department of Health and Human Services replace the current contracting authority under Title XVIII of the Social Security Act with the new Medicare Administrative Contractor (MAC) authority. This mandate is referred to as Medicare Contracting Reform. Medicare Contracting Reform is intended to improve Medicare's administrative services to beneficiaries and health care providers. Currently, there are three Durable Medical Equipment (DME) MACs that handle the processing of DME claims and one A/B MAC (Jurisdiction 3) to handle the processing of both Part A and Part B claims for those beneficiaries located within the states included in Jurisdiction 3. All Medicare work performed by Fiscal Intermediaries and Carriers will be replaced by the new A/B MACs by 2011. Providers may access the most current MCR information to determine the impact of these changes at **www.cms.hhs.gov/MedicareContractingReform** on the CMS website.

March 2007 ICN: 006400